IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PAULA K. STONE,

Plaintiff,

v.

BAYER CORPORATION LONG TERM DISABILITY PLAN and BAYER CORPORATION,

Defendants.

08-CV-356-BR

OPINION AND ORDER
Portland Division

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BROWN, Judge.

This matter comes before the Court on Defendants' Motion (#54) for Summary Judgment and Plaintiff's Cross-Motion (#58) for Summary Judgment. For the reasons that follow, the Court **DENIES** Defendants' Motion for Summary Judgment and **GRANTS** Plaintiff's Cross-Motion for Summary Judgment.

BACKGROUND

I. Long-Term Disability Plan Language

The Bayer Corporation Long-Term Disability (LTD) Plan provides in pertinent part:

> If you are continuously disabled, [long-term disability] LTD benefits begin on the later of:
>
> * The first day of the 27th week after your disability begins
>
> or
>
> * The first day after short-term disability benefits stop.
>
> For LTD benefits to begin, you must be unable to perform the essential duties of your regular occupation. You must provide the company and

> claims administrator periodically with proof of your disability and your disability will need to be medically verified. The claims administrator may ask you to be examined by an independent doctor to verify your continuing disability.
>
> After six months of receiving LTD benefits, you must be "totally disabled" to continue eligibility for benefits. "Totally disabled" means you are unable to work at any job for which you are or could become qualified by education, training, or experience.

Administrative Record (AR) 37.

II. Factual Background

Plaintiff began working for Defendant Bayer Corporation as a pharmaceutical sales representative on November 10, 1997. Plaintiff applied for short-term disability leave on February 9, 1998. Plaintiff did not return to work and applied for LTD benefits on July 31, 1998. Plaintiff began receiving LTD benefits in August 1998. On November 18, 1998, Broadspire Administrative Services, Inc., the company Bayer contracted with to administer its LTD Plan, denied Plaintiff's claim for benefits under the exclusion in the LTD Pan for disabilities resulting from "employment-related mental or emotional stress."

Plaintiff appealed Broadspire's denial to Bayer's ERISA Review Committee on December 28, 1998. The Review Committee upheld Broadspire's denial.

On November 3, 2000, Plaintiff filed an action in this Court, 00-CV-1499-BR (*Stone I*), in which she alleged Bayer violated ERISA, 29 U.S.C. § 1132(a)(1)(B), when it failed to pay

LTD benefits to Plaintiff. On January 15, 2002, Magistrate Judge Dennis James Hubel issued Findings and Recommendation in *Stone I* in which he recommended the Court review the denial of Plaintiff's LTD benefits under an abuse-of-discretion standard, grant Bayer's motion for summary judgment, and deny Plaintiff's motion for summary judgment.

On May 9, 2002, the Court issued an Opinion and Order in *Stone I* in which it adopted the Magistrate Judge's recommendation as to the abuse-of-discretion standard of review, but the Court did not adopt his recommendation as to the merits. The Court noted the parties in *Stone I* agreed Plaintiff was disabled within the meaning of the LTD Plan at the time she applied for LTD benefits. Bayer, nonetheless, denied Plaintiff's claim because it concluded her disability was caused by work-related stress, and, therefore, her disability was excluded under the LTD Plan. The Court concluded Bayer's application of the LTD Plan's work-related stress exclusion was an abuse of discretion because "the record lack[ed] competent expert opinion evidence that Plaintiff's disability was caused by work-related stress."

On January 27, 2003, the Court entered a Judgment in *Stone I* awarding benefits and attorneys' fees to Plaintiff.

On March 23, 2005, Broadspire informed Plaintiff that it had determined Plaintiff could perform sedentary work, and, therefore, she was no longer totally disabled under the terms of

the LTD Plan. Broadspire, therefore, terminated Plaintiff's LTD benefits as of March 31, 2005.

On September 21, 2005, Plaintiff appealed Broadspire's decision to Bayer's ERISA Review Committee. On January 30, 2006, the Review Committee denied Plaintiff's appeal and upheld Broadspire's decision to terminate Plaintiff's LTD benefits.

In their January 30, 2006, denial, the Review Committee noted it was Plaintiff's "medical condition as of March 31, 2005 on which the Committee [was] required to focus because that is the date that she was determined to no longer be disabled." AR 130. The Review Committee noted it examined and relied on peer reviews of Plaintiff's medical records conducted by eleven doctors before Broadspire made its March 31, 2005, decision to terminate benefits as well as "independent third-party reviews" that were conducted by two doctors after March 31, 2005, which included reviews of the materials submitted by Plaintiff with her appeal to the Review Committee. AR 131. The Review Committee also noted the record reflected Plaintiff was awarded Social Security disability benefits in 1997 and that the award was renewed in 2004. Broadspire, however, did not give those decisions "significant weight" because the record before Broadspire did not include the decisions of the Social Security Administration (SSA), those decisions were contrary to the opinions of the doctors who reviewed Plaintiff's medical record,

and

> Social Security determinations apply a presumption in favor of the views of treating physicians, which we do not, and they may be affected by other considerations which do not affect our review, such as the aggressiveness with which a claim is presented or opposed in the agency.

AR 132. Accordingly, Defendants terminated Plaintiff's LTD benefits retroactive to April 1, 2005.

On March 24, 2008, Plaintiff filed a Complaint in this Court against Defendants Bayer LTD Plan and Bayer Corporation (*Stone II*) in which she alleged Defendants violated ERISA, 29 U.S.C. § 1132(a)(1)(B), when they terminated Plaintiff's LTD benefits. Plaintiff sought a judgment for (1) payment of a monthly benefit under the LTD Plan's terms in the net amount of approximately $2,450 per month from the date of the last benefit payment "in or about March of 2005" through the date of judgment pursuant to 29 U.S.C. § 1132(a)(1)(B); (2) a declaration that Plaintiff is entitled to receive a monthly benefit under the LTD Plan as long as Plaintiff remains totally disabled pursuant to the LTD Plan's terms; and (3) pre- and post-judgment interest.

On March 25, 2008, Plaintiff filed an Amended Complaint in *Stone II* containing the same allegations and adding the following request for relief: "For a declaration that Plaintiff is entitled to receive any other benefits that accrue as a result of Plaintiff’s status as a Plan beneficiary with a long term disability, including but not limited to health insurance, life

insurance, dental benefits, supplemental accidental death and dismemberment insurance, and prescription drug coverage."

On January 29, 2009, the Court held a hearing as to the standard of review to be applied in this matter. On that same date, the Court issued an Order that Defendants have a structural conflict of interest, and, therefore, the standard of review that applies is abuse of discretion.

The parties filed Cross-Motions for Summary Judgment as to the merits.

STANDARD OF REVIEW

Although this matter is before the Court on cross-motions for summary judgment, the usual summary-judgment standard under Federal Rule of Civil Procedure 56 is not applicable to ERISA actions. When reviewing a benefit plan's decision to deny benefits, "a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply." *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 942 (9th Cir. 1999).

I. The abuse-of-discretion standard of review applies in this matter.

When an ERISA plan provides the plan administrator with discretionary authority to determine eligibility for benefits, the district court ordinarily reviews the plan administrator's

decision to grant or to deny benefits for an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

"Abuse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest . . . . [T]hat conflict[, however,] must be weighed as a factor in determining whether there is an abuse of discretion." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965 (9th Cir. 2006) (quotation omitted). "A district court when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily . . . than a minor, technical conflict might." *Id*. at 968.

> The level of skepticism with which a court views a conflicted administrator's decision may be low if a structural conflict of interest is unaccompanied, for example, by any evidence of malice, of self-dealing, or of a parsimonious claims-granting history. A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record.

Id. at 968-69 (citations omitted).

Plaintiff bears the burden to establish that she is disabled and, therefore, is entitled to benefits.

Generally the district court only reviews

> the administrative record when considering whether the plan administrator abused its discretion, but may admit additional evidence on *de novo* review. That principle is consistent with *Tremain*, 196 F.3d at 976-79, which permits extrinsic evidence on the question of a conflict of interest. The district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise.

Id. at 970.

"[P]rocedural irregularities in processing an ERISA claim do not usually justify *de novo* review." *Id.* at 972. "There are, however, some situations in which procedural irregularities are so substantial as to alter the standard of review" such as when a plan administrator "engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan." *Id*. at 971. In that instance, the Court must review *de novo* the administrator's decision to deny benefits. *Id*.

"When a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record." *Id*. at 972-73.

> Even when procedural irregularities are smaller, . . . and abuse of discretion review applies, the court may take additional evidence when the irregularities have prevented full development of the administrative record. In that way the court may, in essence, recreate what the administrative record would have been had the procedure been

correct.

Id. at 973.

Accordingly, as the Court concluded in its January 29, 2009, Order, the abuse-of-discretion standard of review applies in this matter.

II. Level of scrutiny.

Although the Court determined it will review Defendants' decision for abuse of discretion, the Court must now determine "the . . . level of scrutiny with which to review the denial." *Peterson v. Fed. Express Corp. Long Term Disability Plan*, No. CV-05-1622-PHX-NVW, 2007 WL 1624644, at *19 (D. Ariz. June 4, 2007) (citing *Abatie*, 458 F.3d at 965). When the administrator of a benefit plan also operates as the funding source, a conflict of interest is "inherent," and generally the court must give it some weight "even if [the conflict is] merely formal and unaccompanied by indicia of bad faith" because it creates an "incentive to pay as little in benefits as possible to plan participants." *Abatie*, 458 F.3d at 965-66. In addition, when determining the level of scrutiny to apply, courts also may consider familiar factors such as evidence of malice, self-dealing, “a parsimonious claims-granting history,” inconsistent reasons for denial, inadequate investigation into a claim, failure to credit a claimant's reliable evidence, a history of denying “benefits to deserving participants by interpreting plan terms incorrectly or by making

decisions against the weight of evidence in the record," and procedural irregularities. *Id. at* 968, 972. Defendants here have a structural or inherent conflict of interest. The Court, therefore, must give that fact "some weight" when reviewing Defendants' decision to deny Plaintiff's claim for benefits.

Defendants contend their conduct warrants a low level of scrutiny by the Court. Defendants rely on *Metropolitan Life Insurance Company v. Glenn* to support their position. In *Metropolitan Life,* the Supreme Court noted

> when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. . . . In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. [A] conflict of interest. . ., for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances.

128 S. Ct. 2343, 2351 (2008)(citations omitted). Defendants note they have taken steps to reduce any potential bias and to promote accuracy when processing claims including hiring Broadspire, an independent claims administrator who is paid only a flat fee without incentives; setting up the ERISA Review Committee, which

is not paid for its efforts; and setting up a trust administered by an independent third party and funded in part by Bayer Corporation and in part by participants.

Plaintiff, on the other hand, contends the Court should review Defendants' decision with a high level of scrutiny because Defendants failed to investigate Plaintiff's claim adequately and ignored favorable "medical and other information relevant to a full and fair review of the claim."

In *Abatie v. Alta Health & Life Insurance Company*, the Ninth Circuit found

> [a] court may weigh a conflict [of interest] more heavily if, for example, the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or [to] ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record.

458 F.3d 955, 968-69 (9th Cir. 2006)(citations omitted). Here the record reflects the ERISA Review Committee provided several medical experts with Plaintiff's medical records and information and followed their recommendations regarding Plaintiff's level of disability. Defendants also retained physicians to review Plaintiff's appeal of Broadspire's decision. Finally, the record reflects the ERISA Review Committee required one of its members to review Plaintiff's entire claim and appeal files. Neverthe-less, the record also reflects Defendants provided Plaintiff with

benefits from November 1998 to March 2005 (*i.e.,* for over six years) because the Court ordered them to do so and terminated her benefits on March 31, 2005, which was only three months after paying Plaintiff her back benefits. In addition, although the ERISA Review Committee stressed it terminated Plaintiff's benefits because it determined she was no longer disabled as of March 31, 2005, the reports of several of the reviewing physicians on whom the ERISA Review Committee relied were written well before March 31, 2005, while Defendants were still providing Plaintiff with LTD benefits.

On this record, the Court concludes a "moderate level" of scrutiny of Defendants' decision to terminate Plaintiff's benefits is appropriate.

DISCUSSION

On January 30, 2006, Defendants upheld the termination of Plaintiff's LTD benefits on the ground that she did not establish she was "incapable of performing any work for which she is or could become qualified by education or training." AR 132.

Applying the abuse-of-discretion standard of review, the Court must determine whether Defendants abused their discretion when they terminated Plaintiff's LTD benefits. An administrator's decision is an abuse of discretion when it is "'without reason, unsupported by substantial evidence or erroneous as a

matter of law.'" *Riffey v. Hewlett-Packard Co. Disability Plan*, No. CIV. S-05-1331 FCD/JFM, 2007 WL 946200, at *14 (E.D. Cal. Mar. 27, 2007)(quoting *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993)). If an administrator's decision has a rational basis, the court may not substitute its judgment for that of the administrator's determination as to eligibility for plan benefits even if the court disagrees with the administrator's decision. *Id.* Under the abuse-of-discretion standard, the court's inquiry "is not into whose interpretation of the evidence is most persuasive, but whether the plan administrator's interpretation is unreasonable." *Clark v. Wash. Teamsters Welfare Trust*, 8 F.3d 1429, 1432 (9th Cir. 1993) (quotation omitted). Finally, "the focus of an abuse of discretion inquiry is the administrator's analysis of the administrative record - it is not an inquiry into the underlying facts." *Riffey*, 2007 WL 946200, at *14 (citing *Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955, 957 (9th Cir. 2002)).

Plaintiff contends the fact that Defendants cannot point to any new medical evidence that shows Plaintiff's condition improved after March 31, 2005, to a degree that she is no longer disabled weighs heavily against Defendants' decision to terminate her disability benefits. Defendants, in turn, rely on the reports of a number of reviewing doctors to support their

decision to terminate benefits.[1] As noted, however, several reports on which Defendants rely address Plaintiff's condition before March 31, 2005, during which time Defendants paid LTD benefits to Plaintiff.

For example, in May 2003, Gerald Goldberg, M.D., a reviewing neurologist, opined Plaintiff's neurological condition did not preclude her from "any type of work." AR 370-74. In June 2003, Russell Superfine, M.D., an internal medicine specialist, opined Plaintiff was not precluded from "any type of work." AR 375-77. In June 2003 and August 2004, Ira Feldman, M.D., a reviewing cardiologist, concluded Plaintiff was not precluded from performing either her own occupation or "any occupation." AR 378-80, 389-91. Similarly, in July 2004, four other reviewing medical specialists found Plaintiff was not precluded from "any type of work." As noted, each of these opinions referenced Plaintiff's symptoms before March 31, 2005, during the time Defendants concluded Plaintiff was eligible for benefits. The Court, therefore, accords these opinions little weight in determining whether Defendants abused their discretion when they

[1] The parties do not address whether the policy requires Defendants to show Plaintiff's condition "improved" after March 31, 2005. *See Torres v. Reliance Standard Life Ins. Co.*, 07-CV-202-BR (D. Or. Jan. 15, 2010). Accordingly, the Court construes the parties' arguments as to whether Plaintiff's condition improved only as they relate to the question whether Defendants abused their discretion in determining Plaintiff was no longer eligible for disability benefits.

terminated Plaintiff's benefits in March 2005.

Defendants also rely on reports of three reviewing physicians enlisted by the ERISA Review Committee to review Plaintiff's medical record, which included records produced by Plaintiff to establish her continued disability after March 31, 2005. In November 2005, James Wallquist, M.D., an orthopedic surgeon, opined "the medical documentation provided pertaining to [Plaintiff's] musculoskeletal system . . . fails to support a functional impairment that would preclude [Plaintiff] from engaging in any occupation from 3/31/05." AR 419. In December 2005, Richard L. Green, M.D., opined Plaintiff was not "totally disabled from performing her position of pharmaceutical representative" or "from employment in any position for which she could become qualified by education, training or experience" from "an allergy/immunologic perspective." AR 455. Finally, in December 2005, Jon B. Tucker, M.D., an orthopedist, found his "diagnostic evaluation did not reveal any orthopedic diagnosis that confers disability for her occupation." AR 458.

Plaintiff, however, points to reports of her treating physicians after March 31, 2005, in which they opine Plaintiff's condition has not improved and that she remains disabled. For example, on April 19, 2005, John McAnulty, M.D., noted Plaintiff suffers from severe allergies, including allergies to "medical environments" to a degree that "she simply cannot enter any

medical facility, clinic or office and even being around medical personnel has resulted in allergic flare-ups" that cause her to be unable to "get the appropriate next step in cardiac care[, which] . . . results in complete disability." AR 1943. On July 13, 2005, Franklin Coale, M.D., noted Plaintiff had "been housebound for the last 18 months because of mold sensitivities and multiple anaphylactic reactions." AR 1940. Similarly, on September 1, 2005, Gunnar Heuser, M.D., opined Plaintiff suffered from Toxic Encephalopathy and "at times life threatening allergic reactions brought on by Immune System Dysfunction as well as Asthma and Reactive Airway Disease." AR 1944.

Defendants, however, correctly point out that plan administrators in the ERISA context are not required to give greater weight to a plaintiff's treating physicians. *Black & Decker Disab. Plan v. Nord,* 538 U.S. 822, 834 (2003)("courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."). Nevertheless, as part of its moderate level of scrutiny of Defendants' decision to terminate Plaintiff's benefits, the Court necessarily will consider the record as a whole and, in particular, whether Plaintiff's condition improved or substantially changed between

the time Defendants initially deemed her eligible for benefits and the time Defendants reversed their decision. Accordingly, the Court gives moderate weight to the opinions of Plaintiff's treating physicians that Plaintiff continued to suffer debilitating health problems after Defendants terminated Plaintiff's benefits.

Plaintiff also contends Defendants abused their discretion when they failed to consider Plaintiff's award of disability benefits from the SSA in 1997 and 2004 after they encouraged Plaintiff to apply for such benefits. In *Metropolitan Life*, the Supreme Court found the Sixth Circuit did not err when it concluded Metropolitan Life abused its discretion by terminating claimant's benefits because the court

> found questionable the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency's finding in concluding that Glenn could in fact do sedentary work. This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because MetLife's seemingly inconsistent positions were both financially advantageous). And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence.

128 S. Ct. at 2352. Here the ERISA Review Committee did not

ignore the SSA's finding that Plaintiff was disabled even though it accorded the SSA's finding little weight on the grounds that it did not have the SSA's decision to review; SSA determinations apply a "presumption in favor of the views of treating physicians," which the ERISA Review Committee is not required to do; and the doctors who reviewed Plaintiff's medical record did not find Plaintiff was disabled.

To further support Plaintiff's contention that Defendants abused their discretion, Plaintiff points to the fact that in *Stone I*, Defendants conceded Plaintiff was disabled at the time she requested LTD benefits. In *Stone I*, Defendants denied Plaintiff's claim on the ground that her disability was caused by work-related stress. After the Court concluded Defendants abused their discretion when they denied Plaintiff's claim on that basis and Defendants paid Plaintiff her back benefits, Defendants then proceeded to terminate Plaintiff's benefits after only three months on the ground that she was no longer disabled. Defendants, therefore, have a history of denying Plaintiff's claims and providing inconsistent reasons for denying Plaintiff's claims.

After applying the abuse-of-discretion standard and employing a moderate level of scrutiny to this record, the Court finds Defendants abused their discretion when they terminated Plaintiff's LTD benefits. The Court, like the *Metropolitan Life*

Court, gives weight to the fact that Defendants in this case encouraged Plaintiff to argue to the SSA that she could not do any work; Defendants received some of the benefits of Plaintiff's success with her application for Social Security disability benefits through the provision of the LTD Plan that allows Defendants to decrease Plaintiff's LTD disability benefits by the amount of any SSA disability benefits she receives; and yet Defendants ultimately gave the SSA's findings and award of benefits little weight. In addition, although Defendants conceded in *Stone I* that Plaintiff was disabled, Defendants have not identified sufficient evidence in the record to establish such disability which existed for years before no longer was present. In short, it is not reasonable to conclude on this records that Plaintiff's established disability simply ceased to exist.

Accordingly, the Court grants Plaintiff's Motion for Summary Judgment and denies Defendants' Motion for Summary Judgment.

CONCLUSION

For these reasons, the Court **GRANTS** Plaintiff's Motion (#58) for Summary Judgment and **DENIES** Defendants' Cross-Motion (#54)

for Summary Judgment.

IT IS SO ORDERED.

DATED this 15th day of January, 2010.

/s/ Anna J. Brown

ANNA J. BROWN
United States District Judge